

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

90 - Stem Cell Transplantation

(Rev. 776, Issued: 12-06-05, Effective: 11-28-05, Implementation: 01-03-06)

Stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. Autologous stem cell transplantation (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

Bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. See Pub. 100-03, National Coverage Determinations Manual, section 110.8.1, for a complete description of covered and noncovered conditions. The following sections contain claims processing instructions for carrier claims. For institutional claims processing instructions, please refer to Pub. 100-04, chapter 3, section 90.3.

90.1 - General

(Rev. 486, Issued: 03-04-05, Effective Date/Implementation Date: N/A)

- **Allogeneic Stem Cell Transplantation.**

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

- **Autologous Stem Cell Transplantation**

Autologous stem cell transplantations is a technique for restoring stem cells using the patient's own previously stored cells. Autologous stem cell transplants are covered for certain specified diagnoses for services rendered on or after April 28, 1989.

90.2 - HCPCS and Diagnosis Coding

(Rev. 526, Issued: 04-15-05, Effective: 03-15-05, Implementation: 05-16-05)

Allogeneic Stem Cell Transplantation

- Effective for services performed on or after August 1, 1978:

- For the treatment of leukemia or leukemia in remission, providers shall use ICD-9-CM codes 204.00 through 208.91 and HCPCS code 38240.

- For the treatment of aplastic anemia, providers shall use ICD-9-CM codes 284.0 through 284.9 and HCPCS code 38240.

- Effective for services performed on or after June 3, 1985:

- For the treatment of severe combined immunodeficiency disease, providers shall use ICD-9-CM code 279.2 and HCPCS code 38240.

- For the treatment of Wiskott-Aldrich syndrome, providers shall use ICD-9-CM code 279.12 and HCPCS code 38240.

- Effective for services performed on or after May 24, 1996:

- Allogeneic stem cell transplantation, HCPCS code 38240 is not covered as treatment for the diagnosis of multiple myeloma ICD-9-CM codes 203.00 or 203.01.

- Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services performed on or after April 28, 1989:

- For the treatment of patients with acute leukemia in remission who have a high probability of relapse and who have no human leucocyte antigens (HLA) matched, providers shall use ICD-9-CM code 204.01 lymphoid; ICD-9-CM code 205.01 myeloid; ICD-9-CM code 206.01 monocytic; or ICD-9-CM code 207.01 acute erythremia and erythroleukemia; or ICD-9-CM code 208.01 unspecified cell type and HCPCS code 38241.

- For the treatment of resistant non-Hodgkin's lymphomas for those patients presenting with poor prognostic features following an initial response, providers shall use ICD-9-CM codes 200.00 - 200.08, 200.10-200.18, 200.20-200.28, 200.80-200.88, 202.00-202.08, 202.80-202.88 or 202.90-202.98 and HCPCS code 38241.

- For the treatment of recurrent or refractory neuroblastoma, providers shall use ICD-9-CM codes Neoplasm by site, malignant, the appropriate HCPCS code and HCPCS code 38241.

- For the treatment of advanced Hodgkin's disease for patients who have failed conventional therapy and have no HLA-matched donor, providers shall use ICD-9-CM codes 201.00 - 201.98 and HCPCS code 38241.

- Autologous Stem Cell Transplantation.--Is covered under the following circumstances effective for services furnished on or after October 1, 2000:

- For the treatment of multiple myeloma (only for beneficiaries who are less than age 78, have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma, and have adequate cardiac, renal, pulmonary and hepatic functioning), providers shall use ICD- 9-CM code 203.00 or 238.6 and HCPCS code 38241.

- For the treatment of recurrent or refractory neuroblastoma, providers shall use appropriate code (see ICD-9-CM neoplasm by site, malignant) and HCPCS code 38241.

- Effective for services performed on or after March 15, 2005, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan (HDM) together with autologous stem cell transplantation (HDM/AuSCT) is reasonable and necessary for Medicare beneficiaries of any age group for the treatment of primary amyloid light chain (AL) amyloidosis, ICD-9-CM code 277.3 who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and,
 - Cardiac left ventricular ejection fraction (EF) greater than 45%.

90.3 - Non-Covered Conditions

(Rev. 526, Issued: 04-15-05, Effective: 03-15-05, Implementation: 05-16-05)

Autologous stem cell transplantation is not covered for the following conditions:

- Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);
- Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);
- Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0 through 199.1); or
- Effective for services rendered on or after May 24, 1996 through September 30, 2000, multiple myeloma (ICD-9-CM code 203.00 and 203.01).
- Effective for services on or after October 1, 2000, through March 14, 2005, for Medicare beneficiaries age 64 or older, all forms of amyloidosis, primary and non-primary (ICD-9-CM code 277.3)
- Effective for services on or after 10/01/00, for all Medicare beneficiaries, non-primary amyloidosis (ICD-9-CM code 277.3).

NOTE: Coverage for conditions other than those specifically designated as covered in 90.2 or specifically designated as non-covered in this section will be at the discretion of the individual carrier.